J.P. FARLEY CORPORATION
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P.O. Box 458022 • Westlake, Ohio 44145
Toll Free: 800.634.0173 • **Fax:** 440.250.4301
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PRIMARY CARE PHYSICIAN REQUEST

MUST BE COMPLETED IN FULL

Employer	Branch Location		Group Number
Employee's Last Name	First	M.I.	Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
Home Address	Street	☐ Check if new	Social Security Number (000-00-0000)
City	State	Zip	If Name Change, Give Former Name
Home Phone ( ) -	Work Phone ( ) -		Email Address

Please DECLARE YOUR PRIMARY CARE PHYSICIAN by completing this form.

This form should be completed to declare a primary care physician for you and all of your dependents. The information will be held confidential and will be used only to verify the selection of your Primary Care Physician. Please return this form to the address below to assist in proper claims processing.

PARTICIPANT / EMPLOYEE PRIMARY CARE PHYSICIAN INFORMATION:

Physician's Full Name:			Physician's Practice / Group Name (if applicable):	
Street Address	City	State	Zip	Tax ID Number (if available):
Phone Number: ( ) -	Appointment Scheduled? ☐ No ☐ Yes If yes, when is it scheduled? (MM/DD/YYYY)			

DEPENDENT INFORMATION: *Please declare a primary care physician for each dependent.*

Dependent Name:				Date of Birth (MM/DD/YYYY)
Physician's Full Name:		Physician's Practice / Group (if applicable):		Tax ID Number (if available):
Street Address	City	State	Zip	Phone Number: ( ) -
Dependent Name:				Date of Birth (MM/DD/YYYY)
Physician's Full Name:		Physician's Practice / Group (if applicable):		Tax ID Number (if available):
Street Address	City	State	Zip	Phone Number: ( ) -
Dependent Name:				Date of Birth (MM/DD/YYYY)
Physician's Full Name:		Physician's Practice / Group (if applicable):		Tax ID Number (if available):
Street Address	City	State	Zip	Phone Number: ( ) -
Dependent Name:				Date of Birth (MM/DD/YYYY)
Physician's Full Name:		Physician's Practice / Group (if applicable):		Tax ID Number (if available):
Street Address	City	State	Zip	Phone Number: ( ) -

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Return: Completed form to:

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